Why Do the Japanese Wear Masks?

A short historical review

Mitsutoshi Horii, Faculty of Tourism and Business Management, Shumei University [About | Email]
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Abstract

For one reason or another, surgical face masks are worn by a considerable number of people in Japan, in their daily lives in public spaces. The practice of mask wearing may be observed in other countries, especially in East Asia, but the Japanese case is probably best known internationally. This article traces the origin and historical development of mask wearing in Japan up to recent years. The driving force of this social practice has been the collective sense of disempowerment. Mask wearing has provided people with a sense of control over a situation which is otherwise experienced beyond their control.

Keywords: mask, Japan, health risk, sense of control, neoliberal subjectivity.

Introduction

The Japan Times on April 30, 2009 informed its English-speaking audience: “Surgical masks are a common sight in Japan... and Europeans are often surprised when they first see them being worn on subways and in public places.” Surgical masks, often known as hygiene masks, were widely worn in flu season, “not just to filter the air they breathe, but to keep from spreading their germs to others, especially since blowing one’s nose in public is frowned upon” (Glionna 2011). They are also commonly used as a protection against hay fever, which is said to be “[t]he biggest reason for the face covering” (The Associated Press 2013).

Masks are used by a significant proportion of Japanese population. Surveys carried out in 2009 indicated that between 22.8 per cent (Interwired 2009) and 48.7 per cent (Hakugen 2010) of respondents wore masks as a protection against influenza, while 76.5 per cent believed that masks could provide effective protection against influenza (Hakugen 2010). Another survey published in 2009 showed that about three out of four respondents were willing to wear masks when suffering from a cough (Pfyzer 2009). In the case of hay fever, two surveys from 2010 indicated that more than 70 per cent of hay fever sufferers used masks (Hakugen 2011; Unicharm 2011).

This article is a short historical review of mask-wearing in Japan. The first section briefly introduces the conceptualisation of mask-wearing in Japan as “risk ritual,” in order to highlight the main characteristics of this social practice, by which the wearer restores a sense of control in the face of uncertainties. The following sections trace the origins of mask-wearing, and examine the historical development of the practice in Japanese society. Originally confined to hospitals, the practice was

disseminated to the general public for the first time during the 1918 Spanish influenza pandemic. This particular usage of masks was then introduced to Japan. Thereafter, in Japan, mask-wearing became deeply embedded in people's lives, in relation to specific health risks, when there are no other seemingly more effective methods. Furthermore, in the 2000s, the discourse around the practice of mask-wearing has been loaded by neoliberal ideology, which increasingly transfers responsibilities for managing health risks from the state to individuals. Mask-wearing has increasingly become its embodiment. The article concludes with the examination of diversification and generalisation of mask-wearing which have been observed in recent years.

'Risk Ritual' of Mask-wearing?

After the 2011 Tōhoku earthquake and tsunami, having observed practices of cleanliness at evacuation shelters in northeast Japan, Steger (2013: 62) made the following remarks on the practice of mask-wearing in these shelters:

> Masks were distributed at the shelters and everyone was encouraged to wear one, but while some women would wear one while preparing rice balls, others would not. The same women also would not always wear a mask when they were cooking. The priest told me to wear a mask when I went out to walk around town because of the dust, though he himself never wore one.

The lack of clearly targeting and systematic usage suggests that the mask-wearing is practiced in an individualistic manner, not necessarily constructing a rigid collective norm around the practice, while it is "socially embedded as a general protective practice" (Burgess and Horii 2012: 1184). Yet, this individualised practise is "closely correlated with Japanese spacial classification" (Ohnuki-Tierney 1984: 27), which constructs "the boundary between the 'inner' sanctum… and the 'polluted' outside" (Palmer and Rice 1992: 323). Mask-wearing and telling others to do so indicate a closer individual engagement to this symbolic order

In the first case above, a mask was worn by a woman not to pollute the food by her breath when cooking. The demarcation established by the mask between the food and herself represents the high level of care this woman put on food preparation at that particular moment, while it was not expected that others should do the same. In the second case, an older male told his younger female guest to wear a mask, showing his care towards her, implying his wish that she not be polluted by inhaling dust. The fact that this priest himself never wore a mask, however, indicates his carelessness towards his own older male body, though he may also be demonstrating his masculinity, displaying his self-confidence in the resilience of his body.

When mask-wearing embodies certain symbolic order, such an effect of symbolisation upon human behaviour is often termed as "ritual." More specifically, mask-wearing in Japan has been conceptualised as "risk ritual" (Burgess and Horii 2012). It must be noted, however, that 'ritual' is an inherently problematic concept. On the one hand, it is "described as particularly *thoughtless* action —routinised, habitual, obsessive, or mimetic—and therefore the purely formal, secondary, and mere physical expression of logically prior ideas" (Bell 1992: 19, *italic* original). In this sense, it is "a provocative notion" (Grimes 2000: 259), indicating "irrationality" of that action. On the other hand, this apparently thoughtless action is giving profound meaning as "a type of functional or structural mechanism" which reflects collective belief and ideals (Bell 1992: 20). Here, 'ritual' is reintegrated to thoughts. 'Risk ritual' also constructs the same double meaning. The term indicates apparent 'irrationality' of risk discourse in the clinical context in which a probabilistic talk would not increasing the chance of avoiding illness (Crawford 2004), and various apparent risk avoidance behaviours, which do not reduce actual risks they are associated (Moore and Burgess 2011). At the same time,

'risk ritual' articulates the behavioural adaptation to "a pervasive sense of uncertainty" and "a collective sense of disempowerment" (Moore and Burgess 2011: 119), in which "[o]ne must acts as if one is in control" (Crawford 2004: 523).

These double meaning of 'ritual' is further complicated by the vagueness of the concept itself, when 'ritual' is defined by such characteristics as "routinisation, regularisation, repetition," which "lie at the basis of social life itself" (Goody 1977: 28). In other words, the term is analytically useless when social life itself can be seen as 'ritual' one way or another. When the category of 'ritual' is constructed as something ontologically independent from the non-ritual, therefore, the demarcation made is inevitably ideologically loaded. For instance, it was since the early twentieth century when the term 'ritual' came to signify "symbolic activity as opposed to the instrumental behaviour of everyday life" (Asad 1993: 55). Historically, this demarcation reflects "a particular hegemony in Western intellectual life" which is defined by "reason" and the scientific pursuit of knowledge (Bell 1992: 6). In this light, ritual is often conceptualised as the second-class category of action, which is to be subject to a "Western," "objective," "scientific," "technically instrumental," in short "superior" gaze, which has been given authority to interpret and construct meaning. Thus, application of 'ritual' to an analysis of a non-Western social life would not avoid an accusation of being 'orientalist.'

The term, however, is useful in an expressive purpose. The concept of 'ritual' in Goffman's work on 'interaction ritual' (Goffman 1972), for example, construct a sense of detachment from the kinds of behaviour he analyses—"from the smallest facial expression to the week-long conference" (Goody 1977: 34). In the context of sociological studies of risk, for example, Power (1997) constructs a detached position of his observation from an explosion of auditing activity in the UK and North America by conceptualising it as 'rituals of verification.'

At the same time, the conceptualisation of mask-wearing as 'risk ritual' is more than the provocation of detachment, although the term 'ritual' is problematic as an analytical concept. What is important for the purpose of this article is the kind of social dynamics articulated by the 'risk ritual' literature. In the face of a threat and uncertainty, a certain practice, carried out in the hopes of reducing certain risks, regardless of whether it actually reduces these risks, provides individuals with the sense of personal control over a situation which would otherwise be experienced as beyond control. In this sense, this kind of behavioural pattern absorbs a sense of vulnerability provoked by the threat or uncertainties of risks.

In other words, mask-wearing emerges in the state of disempowerment as an act of empowerment. In the face of a threat and uncertainty, mask-wearing, carried out in the hopes of reducing certain risks, regardless of whether it actually reduces these risks, provides individuals with a sense of personal control over the situation, which would otherwise be experienced as beyond control. In this sense, it is mask-wearing which here absorbs a sense of vulnerability provoked by the threat or uncertainties of risks. It is not certain whether all the examples mask-wearing in Japan are effective for reducing actual health risks, especially, in relation to influenza (Takizawa 2010). What is sociologically more important is the fact that a significant number of Japanese people immediately started to wear masks when perceiving health risks in the air, almost instinctively, prior to any scientific arguments for or against, in their hopes of avoiding these risks. Mask-wearing absorbs anxieties over invisible threats and uncertainties. It seems to be a well-established and flexible coping strategy for Japanese people, adaptable to diverse kinds of risks and uncertainties.

The Origin

It was within the Western medical practice of the sixteenth century where the first mask as a measure of personal prophylaxis appeared (Lien-teh 1926: 391-392). By the end of the nineteenth century,

gauze masks were used by surgeons in the operating theatre "for protecting patients against cross-infection" (Spooner 1967: 76). At the dawn of the twentieth century, they were used in hospitals "for protecting personnel attending patients with contagious disease" (Spooner 1967: 76). It was in 1918 when the practice of mask-wearing, which had been "a sensible caution in the sickroom," became "just as sensible in every situation" (Crosby 2003: 101). In a desperate attempt to control the spread of Spanish influenza, surgical masks were applied to ordinary people in streets and department stores. A number of cities in the US issued legislation requiring mask-wearing for all citizens in public places (Barry 2005; Crosby 2003; Blakely 2006; Luckingham 1984; Tomes 2010). This is known as the "Mask Order." The same practice was also recommended in the UK (Loeb 2005; Blakely 2006).

Although the general public reacted negatively to this compulsory mask-wearing, San Francisco, for example, achieved a sharp decline of new flu cases after the enforcement of its Mask Order. This case became known as a successful battle against Spanish influenza. Barry (2005: 375), however, argues: "The city had simply been lucky." Nonetheless, in contrast to "the paralysing fear found in too many other communities," people in San Francisco "felt a sense of control:" "They thought that they had controlled it, that they had stopped it" (Barry 2005: 375). Although these masks might have been in fact useless against the influenza virus itself, they gave people a sense of control over the pandemic.

The Japanese post-Spanish influenza pandemic report *Ryūkōsei Kanbō* (Naimushō Eiseikyoku 2008 [1922]) tells that Japanese health authorities had learnt by autumn 1918 how Western nations had responded to the pandemic, including mask-wearing in San Francisco and other cities. In February 1919, according to the report, the National Public Health Bureau instructed local authorities to encourage people to wears masks in places where flu patients were admitted and other places with a high risk of infection. This was followed by more detailed guidelines, which added mask-wearing in crowds, on trains, and on trams. Notably, mask-wearing was recommended to healthy people, but not to flu patients. Meanwhile, those who were coughing and sneezing were told to cover their noses and mouths with handkerchiefs or *tenugui* (literally, hand clothes), but not by masks. In October 1919, local authorities were instructed to provide free masks to those who could not afford them. Theatres, cinemas, and buses were added to the list of the places where masks should be worn.

Masks had been used in the early nineteenth-century by some Japanese miners (Naito 1989), and the first commercial dust respirator was invented in 1917 (Saito 2011: 16). Nevertheless, masks were not widely used in mines and chemical factories until 1925 (Saito 2011: 16), and these industrial masks were of a different kind to that which people used on the street during the Spanish influenza pandemic. Some suggest that mask-wearing in Japan should be traced back to the Manchurian Pneumonic Plague between 1910 and 1911 (Steger 2013; Nishiura 2006). It was likely that Japanese health authorities knew about these plague masks, given the fact that since 1905, several parts of Manchuria had come under the direct control of the Japanese Empire. It is important to stress, however, that in this particular event, the use of masks by the general population was neither recorded nor recommended. A close reading of literature about this plague indicates that masks were strongly recommended for "plague patients and suspect cases" and "the sanitary staff" (Strong, Patrie, and Stanley 1912). Where it became a requirement, people often resisted (Strong, Patrie, and Stanley 1912: 303). Given this, it is unlikely that masks were widely worn by local residents outside of the healthcare setting.

To emphasise the limited impact of the 1910-1911 Manchuria plague, and significance of Spanish Flu, upon the Japanese practice of mask-wearing, it should be noted that stories on masks had not appeared in the media before late 1918. In the case of two major national newspapers (*Asahi Shimbun* and *Yomiuri Shimbun*), *Asahi Shimbun* on 7th December 1918 reported the Mask Order in the US, and *Yomiuri Shimbun* on 26th January 1919 published a picture of a New York street cleaner wearing a flu mask. Soon after Japanese cases of Spanish influenza were confirmed, *Yomiuri Shimbun* on 4th February 1919 recommended masks, explaining these were being used in the US against the

pandemic. In *Asahi Shimbun*, the first advertisement of "influenza prevention masks" appeared on 27th February 1919. It was from January 1920, when the second wave of Spanish Flu hit Japan, that articles on flu masks appeared in much greater numbers in both newspapers.

Prior to the Spanish Influenza, there had been established social practices associated with flu-like illness. These include paper stickers, faith healings, naming flu in a humanised way, and so forth (Sakai 2008: 142-154). These are "attempts by ordinary people to come to terms with an invisible threat and to exert some sort of psychological control over their world" (Palmer and Rice 1992: 323). The practice of paper stickers, for example, was widespread during the 1889-1890 pandemic, in spite of the effort of public health authorities to dismiss it (Ohmi 2009: 241).

This popular practice re-emerged during the Spanish Flu pandemic, and was again publicly denounced (Palmer and Rice 1992). The custom of paper stickers might not have disappeared completely, but this time, the public health authorities were more successful in propagating 'modern' preventative methods to the general public. In 1919, with help from the police, public health authorities started the propagation of masks, gargling, and inoculation as the three primary preventive measures against influenza. The printed word was the main method of communication between health authorities and the general public (Naimushō Eiseikyoku 2008 [1922]: 131-269). In these, mask-wearing was recommended to the healthy general public.

In their study of the Spanish Flu pandemic in Japan, Rice and Palmer (1993: 402) make the following remarks about mask-wearing during that time:

> Police were ordered to wear masks in public in 12 prefectures, and masks were made compulsory for all members of the armed forces. In some places, people entering theatres and cinemas were required to put on masks, and some prefectures insisted that masks be worn on public transport. Presumably, masks would have been in very short supply in the opening phase of the 1918 epidemic, but retailers and manufacturers were apparently quick to respond to demand, and masks were a major feature of the 1919 and 1920 epidemics. In some prefectures, material was purchased by the prefectural office and sent to schools where the girls made masks by the hundred. The prefectures also paid for distribution, and the poor families and burakumin (outcastes) received free masks in some districts. Police and voluntary organizations such as Red Cross, Patriotic Women's Association, Flower Day Society, the Private Hygeine Association, and Buddhist Women's groups helped distribute masks.

Mask production, distribution, and use became a national event. The nation was brought together through the mask, which constructed a sense of control over the invisible threat of pandemic. The practice of mask-wearing had become the embodiment and the symbol of national defence against the invisible threat of the influenza.

In contrast to the American "Mask Order," mask-wearing in Japan was well received by the public. The post-pandemic report *Ryūkōsei Kanbō* (Naimushō Eiseikyoku 2008 [1922]) indicates high level of mask-wearing in Japan. In Fukui Prefecture in 1920, for example, it was estimated, according to information obtained from 14 police stations, that some 80 per cent of all households were using masks (Naimushō Eiseikyoku 2008 [1922]: 207-210). While in the US compulsory mask-wearing was seen by the public as going against the modern value of civil liberty (Barry 2005; Crosby 2003; Blakely 2006; Luckingham 1984; Tomes 2010), the Japanese general public seem to have accepted mask-wearing without resistance. In Japan, masks symbolised the arrival of modernity. A series of campaign posters was published by the public health authority in 1921 (Naimushō Eiseikyoku 2008 [1922]: 158-162: 185-187). Some of these depicted monsters, symbolising influenza, which were to be expelled by modern preventative methods such as masks, gargling and inoculation. In early twentieth

century Japan, when “objects of fantasy and folk belief,” such as “ghosts, goblins, monsters, and mysteries of every sort” appeared, they were likely to represent “the irrationality of pre-modern mentalities” and “an obstacle to a modern trajectory anchored by a scientific understanding of the natural world” (Figal 1999: 6). When the monster of influenza was to be dispelled by the mask, wearing masks became the embodiment of modernity. The general acceptance of mask-wearing by the public might indicate the state’s successful mobilisation of its citizen, which Garon (1998) terms “moral suasion.”

Flu Vaccine and Hay Fever

Thereafter, the practice of mask-wearing continued through the war years into the postwar period. A close reading of national newspaper articles, which mention mask-wearing throughout this period, indicates the following trend. What had briefly emerged by the 1930s was mask-wearing by those coughing and sneezing (not to spread their germs to others), although a much stronger emphasis remained on mask-wearing by the healthy public. After the Second World War, mask-wearing became recommended almost exclusively to healthy people (not to those coughing and sneezing) to prevent them from catching cold and flu. The flu mask, however, disappeared in the 1970s, during the time when flu vaccinations rose, while the hay fever mask was introduced at the same time. Nevertheless, as flu vaccination declined in the late 1980s, the flu mask reappeared.

In 1949, the arrival of Italian influenza was initially received by national newspapers with confidence in the form of a national inoculation plan against it, without recommending masks. Masks were recommended, however, by the end of January 1950, when the effectiveness of vaccines was questioned and the production of vaccines was suspended. When Asian influenza arrived in Japan in May 1957, although public health authorities again saw flu vaccination as the only effective line of defence against it, the flu vaccine was not yet available. Therefore, they had to turn their blind eyes on mask-wearing by healthy individuals, without recommending it, but describing it “a national custom” (Kojima and Omura 1960: 88). Public health authorities left mask-wearing to take its own course as “a compromise to social customs” (Kojima and Omura 1960: 88).

The national mass flu vaccination programme started in 1962, targeting the 6 to 15 year-old group (Reichert 2002). This intended to control epidemics in the community, by targeting schoolchildren in order to control the spread of the flu in schools first (Reichert et al 2001). The level of vaccine coverage among Japanese schoolchildren had gradually risen throughout the 1970s and reached its highest peak in 1983 and 1984, with its ratio estimated up to about 85 per cent (Hirota and Kaji 2008; Reichert 2002). During the time when flu vaccine gained greater public confidence, flu masks were declining in the background. By the time when Russian flu arrived in Japan in 1977, images and stories of mask-wearing in the media as the symbol of influenza had disappeared.

The mask, however, found a new role annually in early spring—for hay fever, more precisely, *cedar pollinosis*. The first case was discovered in 1963, and by the 1990s, it had become a “national illness” (Inoue 1992). Initially, the recommended treatments included eye-washing, gargling, and anti-histamines. The mask was added to these in the 1970s. The prevalence of Japanese cedar pollinosis increased 2.6-fold between 1980 and 2000 (Kaneko et al. 2005). In 2004, the prevalence ratio in the general population in urban areas was 24.5 per cent (Kaneko et al. 2005). In 2006, Tokyo had an even higher prevalence of 28.2 per cent (Nishihata et al. 2010). Notably, around 80 per cent of these sufferers tried “self-care” methods of avoiding pollen (Okuda 2003), over 70 per cent of which involved mask-wearing (Dake et al. 2003).

In addition to its widely experienced effectiveness in easing the symptoms (Kanda et al. 1988), the use of masks is a measure taken by many cedar pollinosis sufferers due to the relative ineffectiveness of

other methods. For example, the drug treatment of hay fever in Japan is "considered as possible undertreatment" (Takahashi 2008: 410), due to Japanese doctors' reluctance to prescribe effective doses of drugs, resulting from a fear of side effects shared by both doctor and patient (Takahashi 2008). In contrast, the mask is a relatively cheap, easily accessible, and effective, presumably side-effect-free protection against pollen.

In the 1980s, when the hay fever mask became common in Japanese society, flu masks gradually reappeared. This comeback was triggered by the heightened anxieties over flu vaccination. Under the banner of "social protection," the public health authority tried to control influenza by preventing its spread in schools at first. "However, in the late 1980s, questions about this policy and vaccine's efficacy arose, and a campaign against vaccination began" (Hirota and Kaji 2008: 6451). As a consequence, "in 1994, the government discontinued the programme because of growing doubt about its effectiveness" (Reichert et al. 2001: 890). The decline of flu vaccinations directed people to masks again, in the hope of protection against influenza. An example of flu masks' comeback is Asahi Optical's "VIRUS GUARD," which was launched in 1991 and celebrated the 10th year of its commercial success in 2001. Such a business success is an indication of the prevalence of flu masks in the general public throughout the 1990s.

Influenza Guidelines, Self-care, and Self-responsibility

By the first decade of the twenty-first century, masks had been evolved into very different forms from those in the early twentieth century. The mask widely used in 1919 was a thick cloth with a wire frame. It was in the 1930s when the white gauze mask appeared on the market. Then some improvements such as the use of thinner elastic strings have been made. In the 1980s, a mask specifically designed for hay fever sufferers made its appearance. Since then, a number of different types of masks have been produced with a combination of functions. In the recent decade, however, the gauze mask has been almost completely replaced by the so-called "nonwoven mask." By 2007, "nonwoven-based masks comprised 90% of the market" (Ohmura 2008).

In the 2000s, alongside the physical transformation of masks the gauze to the nonwoven, there was another important shift. Although the popularity of hay fever masks continued, at the level of media representation, they suddenly became overshadowed by the swarm of flu masks. The first turning point was in 2003, when the fear of SARS caused a significant rise in the visibility of flu masks in Japanese society, especially in international airports. The second, and probably more significant instance, was the outbreak of Avian influenza in 2004. The latter event made the World Health Organization (WHO) to urge every country "to develop or update a national influenza preparedness plan" according to its recommendations (WHO 2005: 1). In compliance with this, the Japanese government drafted an influenza preparedness action plan in December 2005 (Inter-ministerial Avian Influenza Committee 2007) as well as set up the Pandemic Influenza Experts Advisory Committee (PIEAC).

PIEAC published its first pandemic guidelines in March 2007 (PIEAC 2007a), one chapter of which clarifies the use of masks in the community setting (PIEAC 2007b). First of all, it instructs that "it is extremely important to have persons manifesting high fevers, coughs, sneezes and other symptoms wear masks, as well as to wear masks yourself when you come in contact with such persons" (PIEAC 2007b: 207). Under the heading "cough manner," it urges coughing people to wear masks. As for the mask-wearing by healthy individuals, the guidelines do not actively encourage it, stating that "even if a healthy person wears a mask, he or she cannot completely prevent the inhalation of virus" (PIEAC 2007b: 207), while it does not dismiss the practice either.

This compromising attitude towards mask-wearing by healthy people resulted from a particular

concern shared by the committee. In the process of drafting the guidelines, the committee discussed the idea that if mask-wearing was recommended only to the sick, wearing masks would automatically signify being contagious, so people would not wear masks for fear of being discriminated against (PIEAC 2006). For the sake of preventing the spread of influenza, the committee recommended mask-wearing by both the sick and the well, so as to consequently encourage the former to wear masks.

There was little change in subsequent guidelines. The 2009 guidelines (Inter-ministerial Pandemic and Avian Influenza Committee 2009) recommended the sick to wear, specifically, non-woven masks, while it noted that the non-woven mask could not completely protect healthy individuals against infection. Nevertheless, it indicated that non-woven masks might provide healthy people with a certain degree of protection in the crowd during a pandemic. These guidelines show an even more lenient approach to the mask-wearing by the healthy public.

The term "cough manner," which was mentioned earlier, had originally appeared as "cough etiquette" (*seki echiketto*) in PIEAC's minutes in 2006, as well as in the Japanese version of the government's influenza guidelines. In the popular media discourse, when the term appeared in March 2007, it did not initially mean wearing masks, but covering your nose and mouth with tissue paper or handkerchiefs, when coughing or sneezing. Masks, however, became included in the term in October 2007. Thereafter, "cough etiquette" became almost equal to mask-wearing by those coughing and sneezing. It was said to be "responsibility, rather than consideration, to others" (Asahi Shimbun 2007). In January 2009, in the name of "cough etiquette," the media urged people to have "the awareness not to become a source of infection" (Takemoto 2009).

Mask-wearing by the sick has often been recognised as a good preventative method ever since Spanish Flu. Recommendations of this practice have appeared from time to time. Nevertheless, it had never been so widely propagated. This normalisation of mask-wearing as "cough etiquette" during the 2000s is associated with the transformation of Japanese subjectivity in relation to the neoliberalisation of the Japanese state. In the mid-1990s, Japan entered a period of major change, which has been analysed in terms of "individualisation" (Suzuki et al. 2010), echoing Beck (1992). At the level of the political economy, the Koizumi administration (2001-2006) in particular 'mediated the balance amongst the state, market and society, moving it away from the state and collective responsibility to the market and "individual responsibility" (Hook 2010: 144). The call for "cough etiquette" was a neo-liberal answer to the question of public health policy, specifically, to a pandemic influenza. When the public health provision codifies "cough etiquette," it signifies a partial withdrawal of the state from the provision, increasing demand for individual responsibility for it. As a symbol of this, the government's official influenza prevention campaign poster during the 2009 pandemic, accompanied by the image of a mask, stated that: "The Spread of the Influenza Must Be Prevented by Each Individual!"

The neoliberal ideology also penetrates the mask-wearing by healthy people as protection against health risks. During the 2000s it was promoted as a form of "self-care" of one's health. According to Hook and Tanaka (2007: 109), "the economic stagnation of the 1990s and early 2000s has profoundly shaped the discourse of self-responsibility in terms of how individual citizens organise their everyday lives." In this cultural climate, "Japan's new health policies herald a culture of individual accountability and rational subjectivity" (Manzenreiter 2012: 83). In this context, mask-wearing has become "a disciplinary device in neoliberal politics" (Manzenreiter 2012: 81), which emphasises the responsibility of the individual for one's health.

Unicharm, the developer of the popular 2003 "super three-dimentional mask," proclaims that the product's exceptional commercial success was due to the company's sensible response to the "heightened self-care awareness of people to protect one's health by oneself." When the company

further pushed the brand's flu/cold range in 2008, their advertising campaign of "self-care promotion" was fronted by a cartoon character called "Super Three-Dimensional Mask Man,'" who preaches "the correct self-care practice" against influenza for the forthcoming winter.

As soon as the news of H1N1 was first reported in Japan on 24th April 2009, masks became a symbol of the pandemic (Segawa 2009). When the first Japanese case was reported on 9th May 2009, the mask became a symbol of personal responsibility. The infected Japanese citizens were publicly criticised for failing to wear masks in Canada where they had been infected. This indicates, echoing Hook (2011) and Hook and Tanaka (2007), the neoliberal national ideal of the "normal" citizen of Japan to be "self-responsible" for "self-caring" outside the national border, in this case, by wearing masks. The media was flooded with images of preventative mask-wearing once the first human-to-human transmission of H1N1 in Japan was confirmed on 16th May 2009 (Segawa 2009). Reporters appeared on live TV with masks, speaking from the hospital where the patients were being treated. Masks worn by these reporters represented 'self-care' of their health and 'self-responsibility' to be precautious about the risk of infection. In addition, this symbolised the employers' responsibility to care for their employees. The publication of the 2007 guidelines encouraged employers throughout Japan to draw up their own pandemic guidelines, in which the slightly negative nuances expressed in the government's guideline towards mask-wearing by the healthy public virtually disappeared, and mask-wearing was strongly recommended to their workers. By providing masks to their reporters, TV stations were demonstrating care and responsibility to their employees' welfare as well as disciplining them to be 'self-caring' and 'self-responsible' citizens.

Significantly, Unicharm launched new campaigns after the 2009 pandemic, from September 2009, now with the association of responsible mask-wearing to the family and the economy. One of the two poster campaigns was entitled "Family Masks of Japan," showing a three-generational family where mask-wearing, combined with its associated notion of 'self-responsibility' and 'self-care', embodied the care and love between its members. The other campaign interpellates: "Virus Guard for those who cannot have a rest," and shows people in different occupations all wearing masks in a commuting train. The (self)care of their health, represented by mask-wearing, symbolises the sense of (self)responsibility of workers towards their job and the national economy. In short, a good Japanese citizen wears a flu mask. The successful post-2009 promotion of masks constructs the ideal type of neoliberal individual subjectivity: "Self-motivated individuals," who "actively manage their own health and quality of life" (Manzenreiter 2012: 83).

Conclusion: Further generalisation and diversification in recent years

Historically, the usage of masks had been a collective and targeted response to specific public health risks. Originally, it was believed that masks protected both medical staff and patients from cross-infection. Since 1918, however, it was used to protect the general public from influenza. In Japan, masks were also applied by hay fever sufferers, as well as by those with the symptoms of flu-like illnesses. Mask-wearing since the 2000s adds a moral meaning to the practice. It became a civic duty of those who sneeze and cough not to be a source infection, while for the healthy general public, mask-wearing embodies neoliberal ethics of being self-caring and self-responsible to one's health.

Mask-wearing in Japan has further "dispersed into generalised practice lacking a clear end or purpose" (Burgess and Horii 2012: 1184). In recent years, the media sensationally reported that masks have "been part of everyday streetwear for decades and even spawned their own fashion trends" (de Freytas-Tamura 2009), while some don them "in order to retreat from society" (Demetriou 2011). In these stories, there is something more than mere sensationalism. In 2007, Unicharm, for example, made an effort to embed the mask in people's lives to the level of everyday

clothes, by launching a campaign combining mask-wearing with the latest fashion. In addition, although the prevalence of the phenomenon is yet empirically uncertain, some people do wear masks to retreat from various psychological tensions in social life, for example, by easing the tension between one's inner feeling and facial expression (Sakurai 2013). While the commercial interest attempts to naturalise mask-wearing in everyday life, some apply it to cope with ambivalences in social life. These indicate the further generalisation and diversification of mask-wearing in Japan to the extent that it has no clear target and purpose.

In recent years, mask-wearing has been an almost spontaneous and automatic cultural response to heightened concerns over certain health risks. When the nuclear accident in Fukushima was reported in March 2011, masks were worn to protect against radioactive isotopes. It took only a few days from the accident until masks were sold out in some stores in the Tokyo area, more than 200 kilometers away from the site (Nagano 2011). In February 2013, Japanese media reported that traces of China's air pollution reached southwest Japan (The Asahi Shimbun 2013). By 18 February, the media openly advised people to wear "masks that can screen out microscopic particles" (Schreiber 2013). In early March, as pollution levels rose, some local governments in southwest Japan advised residents to wear masks. Many nurseries and schools asked parents for their children to wear masks.

The reasons for Japanese people wearing masks have diversified. Historically, mask-wearing was a measure to avoid specific health risks, practiced within the medical context. In Japan, however, the use of masks has evolved into a more generalised behavioural adaptation concerning health risks, sometimes without a specific target, so as to include "cosmetic and comfort purposes" (Simonitch 2012). The following conclusion discusses that the driving force of this diversification and generalisation is the sense of disempowerment. Masks are providing the wearer with a sense of control over invisible threats and uncertainties, which would be otherwise experienced as uncontrollable and unsettling.

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About the Author

Mitsutoshi Horii is an Associate Professor at Shumei University in Japan. He is currently working in the United Kingdom at Chaucer College Canterbury, which is an affiliated college to Shumei University and located within the campus of University of Kent in Canterbury. He has published three books in Japanese: *Josei senyō-sharyō no shakaigaku* [Sociology of women-only train carriages] (2009); *Shōshika wa risuku ka* [Is a declining fertility rate a risk?] (2011); *Masuku to nihonjin* [Masks and the Japanese] (2012). His recent publications also include the following articles: "Constructing sexual risk: 'Chikan,' collapsing male authority and the emergence of women-only train carriages in Japan," *Health, Risk & Society* 14.1 (2012), 41-55 (with Adam Burgess); and "Risk, ritual and health responsibilisation: Japan's 'safety blanket' of surgical face mask-wearing," *Sociology of health & illness* 34.8 (2012), 1184-1198 (with Adam Burgess). He is involved in sociological studies of uncertainties. His most recent academic interest involves critical studies of social categories, such as 'religion.'

Email the author